

Initial Application for Permit ☐

Date Received: _____



Town of Bedford

BOARD OF HEALTH

BOARD OF HEALTH
 Town Center Building
 12 Mudge Way
 Bedford MA 01730-2170

Katharine Dagle
Health Agent
Phone: 781-275-6507
Fax: 781-687-6157

Food Establishment - Initial Permit Application

(Application must be submitted at least 30 days before the planned opening date)

1) Establishment Name:																
2) Establishment Address:																
3) Establishment Mailing Address (if different):																
4) Establishment Telephone No:	Establishment FAX No:															
5) Applicant Name & Title:																
6) Applicant Address:																
7) Applicant Telephone No:	24 Hour Emergency No:															
8) Owner Name & Title (if different from applicant):																
9) Owner Address (if different from applicant):																
10) Establishment Owned By: <input type="checkbox"/> An association <input type="checkbox"/> A corporation <input type="checkbox"/> An individual <input type="checkbox"/> A partnership <input type="checkbox"/> Other legal entity _____	11) If a corporation or partnership, give name, title, and home address of officers or partner. <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Title</th> <th style="text-align: left; border-bottom: 1px solid black;">Home Address</th> </tr> </thead> <tbody> <tr><td colspan="3"> </td></tr> <tr><td colspan="3"> </td></tr> <tr><td colspan="3"> </td></tr> <tr><td colspan="3"> </td></tr> </tbody> </table>	Name	Title	Home Address												
Name	Title	Home Address														
12) Person Directly Responsible For Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.)																
Name & Title:																
Address:																
Telephone No:	Fax:															
Emergency Telephone No:																
13) District Or Regional Supervisor (if applicable)																
Name & Title:																
Address:																
Telephone No:	Fax:															

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the board of health on how to obtain copies of 105 CMR 590.000 and the federal Food Code.

Pursuant to MGL Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid state taxes required under law.

26) Signature of Individual or Corporate Name: _____

BEDFORD BOARD OF HEALTH FEE SCHEDULE

Food Service Establishment Permits		February 28 – Expire date
Food Service, Base Fee for up to 100 seats	\$150	
Food Service, 101-200 Seats	\$250	
Food Service, 201-300 Seats	\$350	
Food Service, 301-400 Seats	\$450	
Food Service, over 400 Seats	\$550	
*Retail Food, Small Scale	\$20	
** Retail Food	\$150	
***Retail Food, Supermarket.....	\$300	
Mobile Unit/Push Cart	\$50	
Residential Kitchen	\$50	
Function Halls	\$100	
Church Kitchen	\$0	
Temporary Food Establishment	\$25	
Caterers	\$75	
Frozen Dessert Manufacturer's License	\$25	
Notes:		
* Retail food, Small Scale = less than 18 sq. ft. floor space, with sale of only "Non-Potentially Hazardous" foods.		
** Retail food, up to 3500 sq. ft. floor space of food operations.		
*** "Supermarket" = greater than 3500 sq. ft. floor space of food operations.		